

<b>STATE OF MICHIGAN</b> <b>PROBATE COURT</b> <b>COUNTY</b> <b>CIRCUIT COURT - FAMILY DIVISION</b>	<b>SUPPLEMENT TO CLINICAL CERTIFICATE ON</b> <b>APPEAL OF RETURN TO HOSPITAL</b>	<b>FILE NO.</b>
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In the matter of \_\_\_\_\_

Attached is my certificate (Form PCM 208) setting forth why the above person requires treatment. I further certify and report as follows:

1. The reason(s) for this individual's return to the hospital or center from authorized leave, and the need for treatment in a hospital or center are: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. The plans for further treatment of the individual are: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Should the court rule against the return, I recommend the court consider for this particular individual the following alternatives to a return to authorized leave status, if they should prove available:

- |  |   |
|--|---|
| <input type="checkbox"/> day treatment in a hospital or center.  | <input type="checkbox"/> night treatment in a hospital or center. |
| <input type="checkbox"/> residential placement.  | <input type="checkbox"/> custody of a friend or relative.         |
| <input type="checkbox"/> inpatient treatment at private psychiatric hospital,<br>at a general hospital's psychiatric unit, or a private<br>residential facility. | <input type="checkbox"/> outpatient treatment.                    |
|  | <input type="checkbox"/> home care or homemaker service.          |
|  | <input type="checkbox"/> day activity programs.                   |

- ☐ other: \_\_\_\_\_

\_\_\_\_\_

- ☐ none of the above merits exploration: \_\_\_\_\_

State reasons

\_\_\_\_\_

\_\_\_\_\_

I declare that this certificate has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

Date _____	Signature _____	Title (physician, psychiatrist, etc.) _____
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Do not write below this line - For court use only